LJN exchange 2003

THE JOURNAL OF NIC'S LARGE JAIL NETWORK

National Institute of Corrections

Large Jail Network

Network Mission

The mission of NIC's Large Jail Network (LJN) is to promote the exchange of ideas and innovations among the administrators of the largest jails and jail systems in the U.S.—those having an average daily population of 1,000 inmates.

Network Goals

- To explore issues facing large jail systems from the perspective of those responsible for administering those systems;
- To discuss strategies and resources for dealing successfully with these issues;
- To discuss potential methods by which NIC can facilitate the development of programs or the transfer of existing technology; and
- To develop and enhance the lines of communication among the administrators of large jail systems.

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In This Issue

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Foreword

This issue of the LJN Exchange includes a variety of articles on topics that have been addressed at recent Network meetings. Mental health, jails and public health, and standards have drawn a great deal of interest from the field, and inmate litigation remains an important issue for discussion. It is our belief that these articles will be not only interesting to our readers but also useful additions to the resource information that you may have previously acquired on these topics.

Though the mission of the Large Jail Network continues to be to promote the exchange of ideas and innovation among the administrators of the largest jails and jails systems in the U.S., we recognize that the persons who make up our constituent group of sheriffs, jail administrators, directors of corrections, wardens, chief jailers, superintendents and administrators by other titles has changed dramatically in recent years. Therefore, in 2002 we devoted the work of the Network to several general efforts that were brought to our attention by our members that are worthy of being mentioned here:

- To actively seek participation of jail systems who have a great deal to offer but who have not been involved with the Network;
- To assist administrators who are new to their role and new to the Network;
- To seek new and creative ways to identify and meet the needs of the Network and its members; and
- To identify and increase opportunities to open the Network and our meetings to persons and broader issues that relate to the administration and operation of large jails.

NIC neither evaluates nor endorses the material presented in the LJN Exchange, our role is to provide the vehicle for a free and open exchange of ideas and information. However, the quality and relevance of the Exchange will continue to depend on the willingness of Large Jail Network member agencies to share information on innovative programs and concepts. It is my belief that the articles contributed by network agencies and others demonstrate that there is a commitment to communicating the jail's role as an effective major component of the local criminal justice system.

The success of both the LJN Exchange and the Network will continue to depend on the level of interest and involvement of the large jail systems' administrators. We invite LJN Network members to continue to use this and other NIC services and, more importantly, to inform us as to how we might meet other needs that have not been addressed.

Inmate Litigation:

Results of a National Survey

by
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Over the summer of 2001, I conducted a survey of jail and prison systems about experiences with civil litigation brought by inmates. I recently incorporated some of the results of that survey in a comprehensive look at non-class action federal civil rights litigation brought by inmates (see Margo Schlanger, Inmate Litigation, 116 Harv. L. Rev. 1555 (2003), available at *http://www.law.harvard.edu/faculty/schlanger/*). Here I report in a more focused way on those results. (There is not room here for comprehensive analysis, but I hope to publish a fuller discussion in the fall. The survey instrument itself, along with other relevant information, is available at the same website.)

I distributed the survey to all 50 state prison systems and all the members of the Large Jail Network. I received responses from over half the agencies in each category, an acceptable if not stellar response rate. The results reported here are for 27 state prison systems and 44 large jails (defined, for my purposes, as jails with an inmate count over 1,000 at midyear 1999). The sample demonstrates good regional coverage and no major skew as far as size of inmate population. It's worth noting, however, that the prison surveys were completed largely by lawyers, and the jail surveys largely by high-ranking corrections officials (superintendents, sheriffs, and their second and third in commands, judging by the job titles). This may be important for proper interpretation of the results.

Amount of Litigation

One of the key questions about inmate litigation is just how often correctional agencies and their staff are sued. The answer, it turns out (unsurprisingly) varies by agency—but it varies even more by the type of agency: jail or prison. That is, although the surveys evidence a good deal of variation among large jails and among prisons, there is even more difference between the categories.

The survey asked, "About how many individual inmate lawsuits . . . are filed against your jurisdiction/facility in a year?" While nearly all the prison responses reported that their prison systems become defendants in inmate lawsuits dozens, even hundreds of times each year, jail surveys reported far less litigation. Nearly 90% of the large jails that reported their number of inmate lawsuits per year reported fewer than 50. Part of the explanation is that jails are smaller than prison systems, but even controlling for size, jails are sued less than prisons. I used the answers and each agency's average daily population as reported to the Bureau of Justice Statistics to compute a litigation rate—annual lawsuits per 1,000 inmates—for each survey participant. Among the prison sample, the average annual litigation rate was 27 per 1000 inmates, but for large jails the corresponding figure was just 7. Table 1, below, more fully sets out the distribution of litigation rates across the responding agencies. The last column of Table 1 demonstrates that the jails with the highest rate of litigation per inmate reported about the same amount of litigation as the median prison system.

Table 1. Litigation rates—lawsuits per 1,000 inmates per year

	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
Large jails (n = 44)	2	3	5	9	18
Prisons (n = 27)	6	12	19	38	71

Interestingly, the results from a similar question about class actions (which covered 3 years, instead of 1 year) suggest that class actions follow a very different pattern. The median class action litigation rate—that is, the number of class actions per inmate per year—reported by prison agencies was under 0.5 per 10,000 inmates; for large jails, it was nearly twice as high.

Topics of Litigation

Individual and class action litigation. The survey asked participants to check off each topic about which their agencies had been sued over the past 3 years. The reported topics of lawsuits will not be terribly surprising to any experienced observer. In Table 2, page 3, each column sets out the percentage of facilities that reported at least one individual or class action lawsuit on a given topic, followed by the rank of that topic's incidence in that column. (The topics are listed in their rank order for individual actions against large jails; blanks indicate that no survey response listed the topic.)

While there are no major surprises in the table, the first-place ranking of medical care lawsuits in each column is important. It's also worth pointing out that among large jails, crowding and suicide cases rank only seventh—somewhat lower than I, at least, would have predicted. Also, the differences between jails and prisons are notable. In particular, in non-class action cases, claims about religion rank far higher in prisons than in large jails (first, compared to twelfth), as do claims about disciplinary procedures (fourth, compared to

Table 2. Litigation topics—individual and class action lawsuits. Percentage and (rank) of responding agencies with any litigation on topic.

	Large Jail		Prison	
	Individual (n = 44)	Class action (n = 13)	Individual (n = 27)	Class action (n = 14)
Medical care	91% (1)	14% (1)	89% (1)	26% (1)
Use of force	80% (2)		89% (1)	19% (3)
Personal injury	70% (3)		81% (4)	
Loss or damage to property	66% (4)		81% (4)	
Inmate-on-inmate violence	64% (5)	5% (4)	63% (12)	4% (17)
Law library services	41% (6)		78% (8)	11% (6)
Crowding	36% (7)	7% (3)	52% (16)	22% (2)
Suicide prevention	36% (7)		33% (22)	11% (6)
Sanitation/living conditions	32% (9)		59% (13)	4% (17)
Food services/nutrition/diet	30% (10)	2% (6)	78% (8)	
Disciplinary procedures	27% (11)	2% (6)	81% (4)	7% (13)
Sex (w/officer)	25% (12)	2% (6)	56% (15)	7% (13)
Religious programs or policies	25% (12)		89% (1)	15% (4)
Other	25% (12)		33% (22)	
Search policies	20% (15)	9% (2)	37% (20)	4% (17)
Disciplinary segregation	20% (15)		48% (17)	11% (6)
Visiting, mail, phone	18% (17)	2% (6)	81% (4)	4% (17)
Totality of conditions	18% (17)		48% (17)	11% (6)
Administrative segregation	16% (19)		67% (10)	11% (6)
Security staffing	11% (20)	5% (4)	26% (25)	11% (6)
Recreation	11% (20)		37% (20)	7% (13)
Access to lawyers	11% (20)		44% (19)	11% (6)
Race discrimination	9% (23)	2% (6)	67% (10)	4% (17)
Protective custody	9% (23)		59% (13)	7% (13)
Counseling	9% (23)		33% (22)	15% (4)
Other library services	5% (26)	2% (6)	7% (28)	
Gender equity	2% (27)		22% (26)	4% (17)
Fire safety			11% (27)	

eleventh), visiting, mail, and phone privileges (fourth, compared to seventeenth), administrative segregation (tenth, compared to nineteenth), race discrimination (tenth, compared to twenty-third), and protective custody (thirteenth, compared to twenty-third). All of these differences make sense in light of the longer period of time inmates spend in prisons. Note that because prisons are sued more often, even the low-ranking subjects are still fairly common as topics for lawsuits among prison systems, though not among large jails. As for the class-action litigation, the surveys reported many fewer such cases, but with topics that recur in similar patterns, except that crowding ranks noticeably higher.

Table 3. Court order topics—percentage of agencies reporting each court order topic and (rank)
(Percentages based on total number of agencies reporting any court order)

	Large Jail		Prison	
	Current orders, as of 2001, (n = 19)	Lifted orders, 1996 - 2001 (n = 9)	Current orders, as of 2001, (n = 18)	Lifted orders, 1996 - 2001 (n = 20)
Crowding	74% (1)	67% (1)	44% (3)	40% (3)
Medical care	68% (2)	22% (2)	56% (1)	65% (1)
Disciplinary procedures	37% (3)		33% (5)	30% (8)
Security staffing	37% (3)			20% (12)
Law library services	32% (5)	11% (3)	44% (3)	20% (12)
Use of force	32% (5)		22% (9)	20% (12)
Administrative segregation	26% (7)		28% (7)	30% (8)
Sanitation/living conditions	26% (7)	11% (3)	22% (9)	40% (3)
Food services/nutrition/diet	26% (7)	11% (3)	11% (17)	35% (5)
Recreation	26% (7)	11% (3)	11% (17)	25% (10)
Religious programs or policies	21% (11)		50% (2)	20% (12)
Visiting, mail, phone	21% (11)		33% (5)	35% (5)
Disciplinary segregation	21% (11)		17% (12)	20% (12)
Counseling	21% (11)	11% (3)	17% (12)	20% (12)
Suicide prevention	21% (11)		6% (21)	15% (19)
Access to lawyers	16% (16)		22% (9)	20% (12)
Search policies	16% (16)		17% (12)	10% (23)
Totality of conditions	16% (16)	11% (3)	17% (12)	45% (2)
Sex (w/officer)	16% (16)		11% (17)	5% (25)
Protective custody	16% (16)		6% (21)	20% (12)
Other	11% (21)		28% (7)	
Inmate-on-inmate violence	11% (21)			15% (19)
Fire safety	5% (23)		17% (12)	25% (10)
Other library services	5% (23)	11% (3)	6% (21)	15% (19)
Loss or damage to property	5% (23)			10% (23)
Race discrimination	5% (23)			5% (25)
Gender equity			11% (17)	15% (19)
Personal injury				5% (25)

Court order litigation. At some point since the 1970s many—even most—corrections agencies have been regulated by the terms of a court order. The survey results suggest that the topics of these orders are somewhat different than the topics of lawsuits more generally. Table 3 shows topics of court orders, dividing them into orders still operative at the time of the survey and those lifted between 1996 and 2001. It suggests that among both jail and prisons, crowding in particular is far more common as a topic of court orders than of non-order litigation (that is, crowding ranks far higher in this table than in Table 2). Disciplinary procedures and security staffing are also more prominent in Table 3 than in Table 2.

Litigation Outcomes

Individual lawsuits. The survey asked whether agencies had, over the past 3 years, settled any inmate case "for more than token damages," and whether they had lost any trials in an inmate case in the same period of time. Again, experiences varied.

Table 4. Individual inmate lawsuit settlements and trial losses

	A. No settlements		B. Settlements	
	1. No trial losses	2. Trial losses	1. No trial losses	2. Trial losses
Large jails (n = 44)	42%	8%	44%	6%
Prisons (n = 27)	25%	4%	17%	54%

Table 4 sets out the full results. The agencies grouped in the first two columns (headed "A. No Settlements") reported that over the prior 3 years, they had not settled even a single individual inmate case. Those in the first column (headed "1. No trial losses") had also not lost any cases at trial, while those in the second column had lost at least one case at trial. The last two columns (headed "B. Settlements") are set up similarly and complete the picture.

The difference between the jail and prison samples appears very large. First, more of the prison systems (71%) than the large jails (50%) reported settling cases. This may simply be a function of the greater amount of litigation faced by prison agencies, already discussed. More dramatic, however, is the trial-loss differential between large jails and prisons: 58% of prison systems reported losing at least one trial (see A2 + B2, or 4% + 54%), compared to just 14% of jails (8% + 6%). It seems doubtful that the explanation for this differential is that

Table 5: Topics of individual inmate lawsuit settlements and trial losses

	Large jails (n = 32)	Prisons (n = 31)
Medical care	11	16
Use of force	11	13
Inmate-on-inmate violence	6	9
Sex (with officer or staff)	6	8
Personal injury	4	12
Overdention	4	1
Suicide	3	4
Loss or damage to property	3	3
False arrest/imprisonment	3	2
Disciplinary procedures	2	4
Search policies	0	3

jails win their cases more often than prisons—rather, I suspect that jails are more reluctant to go to trial at all. Similarly, the fact that 44% of large jails have settled cases without experiencing any trial losses at all supports the reputed disinclination of jail administrators/ lawyers to take cases to trial.

Table 5, page 5, summarizes the topics of the settlements and trial losses; it lists each topic that appeared more than once in either the jail or prison samples.

As far as the amount of money paid out in settlements, the survey respondents provided less information. Of 27 prison systems, six (6) reported no non-token losses or settlements; only 11 additional systems provided any information on the amount of damages. Of 44 large jails, 18 reported no non-token losses or settlements; only 14 additional agencies provided any information on the amount of damages. Each group had one outlier agency. (A very large prison system reported about $30 million in damages paid out over 3 years, and a very large jail system reported about $7 million in damages in the same period.) Excluding those outliers, the experience reported even by those who characterized their losses as "non-token" was of more modest damages, with large jails experiencing much larger annual losses than prisons. Table 6 provides details:

Table 6. Individual inmate litigation—annual damages paid (distribution among responding agencies, excluding outliers)

	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
Large jails (n = 14)	$10,000	$25,000	$66,667	$250,000	$633,333
Prisons (n = 11)	$4,703	$12,417	$35,508	$87,657	$130,063

Class actions. The results for similar questions about class actions are also interesting. Most strikingly, all but one jail that participated in class action litigation over 3 years had also settled at least one class action case (though none had experienced a class action trial loss), whereas fewer than half the prison systems that participated in class action litigation either settled or lost a class action case. This suggests that although class actions are less common among jails, they may be more consequential.

The results also confirmed that the stakes in class action litigation are quite high compared to those of individual cases. Those few jurisdictions that reported the amounts they paid out for damages or attorneys' fees in class action settlements listed dollar amounts in the hundreds of thousands or even millions.

Table 7. Incidence and termination of court orders—percentage of respondents

	Jurisdictions with court orders	Jurisdictions with recent terminations of court orders
Large jails (n = 44)	41%	15%
Prison (n = 27)	67%	73%

Court orders. The survey asked, "Does your facility/jurisdiction currently have any court orders (including consent decrees or other settlement agreements) governing any aspect of operations?" and "Has your facility/jurisdiction had any court orders governing any aspect of operations lifted . . . since 1996?" Court orders turned out to be very common, as the first column of Table 7, page 6, demonstrates, and more so among prison systems—41% of jail responses and 67% of prison responses reported current court orders as of 2001. (Note,

Table 8. Litigation-related policy changes described by survey respondents

Individual litigation policy changes

Large jails	Prisons
■ Revised use of force policy and hardened disciplinary penalties for excessive or inappropriate force. ■ Improved access to law library; improved recreation area. ■ Examined release of inmates who are on psychiatric medications. ■ Changed administrative system to remove final authority from staff. Grievances may be forwarded to the county solicitor, who determines if civil rights were violated. If so, matter is referred to the complaint review board and/or county prison board. ■ Changed use of force policy. ■ Changed use of force reporting and suicide policy. ■ Changed transportation rules and policy. ■ Made adjustments in medical services. ■ Changed medical practices. Modified use of force, discipline, search, and other operational policies due to court rulings from other jurisdictions. ■ Changed the way in which inmate property is tracked. ■ Changed medical/mental health intake screening form and practices; provided access to TDD phones. ■ Changed critical incident reporting of events, use of videotaping incident, and use of restraint chair. ■ Application of disciplinary sanction for restitution of damaged property. ■ Changed strip search requirements. ■ Added a general counsel position at the directors' level.	■ Allowed women inmates to live in a previously all-male minimum security facility. ■ Housed inmates in county jails; state supreme court wants faster movements into prisons. ■ Changed policy and practice on suicide prevention. ■ Addressed religious issues. ■ Changed policy on collection of urine samples. ■ Changed strip search policy. ■ Modified property policy. ■ Removed weight bars from institutions. ■ Modified the disciplinary process. ■ Changed policies on religious practices, e.g., providing a religious exemption to the rule that male inmates must have short hair. ■ Instigated a liability response unit within Legal Affairs to conduct litigation management of approx. 2,400 pending inmate civil lawsuits. ■ Introduced Risk Management component. ■ Changed bulk rate mail policy. ■ Modified medical policies. ■ Changed policies on property retention and destruction.

Class action policy changes

Large jails	Prisons
■ Revamped medical policies and procedures. ■ Changed medical care vendors; changed procedures and practices to include increasing available HIV medications in the pharmacy, increasing testing procedures for STDs, and changing dental practices. ■ Changes involved a population cap and medical services. ■ Changes involved sexual harassment and hearing impaired inmates (ADA). ■ Modified search policies; changed demographic percentages in housing units. ■ Changed policy re: use of restraint chair. ■ Changed strip search procedures; tightened up on times for release. ■ Began providing public school education in our jail. ■ Made substantial changes in staffing and method of inmate supervision.	■ Improved provision of mental health services for inmates. ■ Changes involved forced medication; double bunking; medical staffing; and mental health care. ■ Changed our publications procedure. ■ Changes involved contract medical services, policies for AIDS/HIV, and religious programming to provide contract Muslim services. ■ Reduced dependency on prison law libraries; fewer materials available, and inmates have improved access to attorneys. Improved barbershop sanitation practices. ■ Changed use of the Inmate Calling System based on a temporary restraining order. The class in this state court class action was decertified 11 months later, but the changes remain in place. ■ Modified female programs and protective segregation policy.

however, that because reported prison court orders may well apply to just one of many prisons in the system, this distinction may be somewhat spurious.) What is more interesting is the second column, which demonstrates that the prisons were far more likely than jails to get orders lifted—73% of prison systems and just 15% of jails had seen court orders closed out in the preceding 5 years.

Impact of Inmate Litigation

Operational impact. The survey asked questions about the operational impact of litigation, directing the questions at individual (non-class action) litigation, class action litigation, and court orders.

For individual and class actions, the questions were free-form: "Has your department changed any policies/procedures/practices as a result of individual inmate [and class action] lawsuits?" About 70% of survey respondents, for both large jails and prisons, answered yes with respect to individual lawsuits; of those who reported experience with class action litigation, a similar proportion (slightly lower for jails) also answered yes. Many provided details, which show that the changes range from small to quite significant.

Table 8, page 7, paraphrases the changes described by survey respondents. In both jails and prisons, they can be categorized into three types. First are changes relating to the management of the litigation itself—litigation staffing by a new General Counsel, or risk management section; ensuring that evidence is developed by videotape, and so on. Second are general managerial changes, designed to improve the administration's supervision of line staff—augmented reporting requirements, for example. By far the most common changes reported are of a third conceptual type: substantive, operational changes. Medical and mental health care are the most common topics in this category, but use of force, strip searches, and a few other issues make repeat appearances as well.

The survey also asked about the operational impact of court orders, both current and recently lifted. Responses are also reported in Table 8. The survey separated out several possible results—hiring additional personnel, building new housing areas, reducing population, altering programming, or some other kind of change. A majority of both responding jails and prisons with court orders reported hiring additional personnel as a result—both security and medical care were the common augmented staffing areas. New housing and population reduction were even more prevalent than staffing increases among reporting jails, but less so among reporting prisons. (Recall, however, that prisons were more likely to have court orders in the first place.) A majority of prisons with court orders (but a much smaller portion of jails) reported altering their programming as a result.

Overall impact/burden. The survey asked two initial questions about the burdens imposed by individual inmate litigation and class action litigation. The first question asked, "How important is your department's interest in avoiding/managing individual inmate [or class action] lawsuits for policy development or other planning?" The second question asked, "How burdensome are

individual [or class action] lawsuits for your department?" The answers, summarized in Table 9, suggest that although litigation is of real importance to both jail and prison agencies as they develop policy, the burden the litigation poses is definitely manageable.

Comparing jails and prisons, jail officials apparently tend to attach greater importance to the litigation and find dealing with it a more significant burden. (Recall, moreover, that the surveys in the prison sample, but not those in the jail sample, were filled out by lawyers.) The class action responses, though interesting, should be interpreted with caution, because so few of the survey-takers answered the questions.

Table 9. Importance and burden of litigation—percentage of survey respondents and (number)

		Importance		Burden	
		Large jails	Prisons	Large jails	Prisons
Individual litigation	extremely	52% (12)	28% (5)	11% (2)	5% (1)
	quite	30% (7)	28% (5)	50% (9)	27% (6)
	somewhat	17% (4)	44% (8)	33% (6)	59% (13)
	not very	0% (0)	0% (0)	6% (1)	9% (2)
	not at all	0% (0)	0% (0)	0% (0)	0% (0)
Class action litigation	extremely	53% (21)	18% (3)	17% (3)	33% (5)
	quite	25% (10)	41% (7)	11% (2)	13% (2)
	somewhat	13% (5)	29% (5)	28% (5)	27% (4)
	not very	5% (2)	6% (1)	17% (3)	13% (2)
	not at all	5% (2)	6% (1)	28% (5)	13% (2)

The survey also asked respondents to rate, on a five-point scale, the impact of their current and recently terminated court orders on inmate behavior, inmate health, physical plant, staff morale, and overall functioning of their agency (1 being the most negative rating and 5 the most positive). Results for this question appear in Table 10:

Table 10. Impact of court orders on agency

	Large jails			Prison		
	No impact	Impact rating		No impact	Impact rating	
	n	n	median	n	n	median
Inmate behavior	5	11	3.7 (4)	10	10	3.5 (3)
Inmate health	3	14	4.0 (4)	5	16	3.9 (4)
Physical plant	4	14	3.9 (4)	5	16	3.8 (4)
Staff morale	2	14	2.9 (3)	5	15	3.5 (4)
Overall functioning	2	15	3.8 (4)	3	18	3.8 (4)

Survey-takers reported that court orders were largely beneficial to their agencies' mission. Nearly all the ratings were 3s (the midpoint) or above—only one respondent rated any of the impacts of court orders as 1, the most negative, and very few gave even 2 ratings. The one exception is on the ratings on the impact of court orders on staff morale. Three of 15 jail respondents and 5 of 14 prison respondents gave court orders a 2 rating on this topic.

Effects of the Prison Litigation Reform Act

Individual and class action litigation. The survey asked about the impact of the Prison Litigation Reform Act (PLRA) on the total number of lawsuits (individual and class action); the proportions of those lawsuits that are frivolous; and the burden created by each type of lawsuit. The results were strikingly different for jails and prisons, with jail survey-takers far more likely to report no impact. Table 11 presents the results. (Because the prison but not the jail surveys were frequently filled out by lawyers, it is possible that these results are an artifact of lawyers' greater sensitivity to the PLRA's litigation impact, rather than any deep difference between jails and prisons.)

Table 11. Impact of the PLRA—percentage of respondents who experienced "no impact"

	Large jails n (% of respondents)	Prisons n (% of respondents)
No impact on individual lawsuits	21 (48%)	2 (7%)
No impact on class actions	32 (73%)	6 (22%)

Among those survey-takers who did report that the PLRA had changed their experience, nearly all reported a decrease in number, frivolous proportion, and burden. The most interesting aspect of these results is that more survey-takers noticed a decline in the number of lawsuits and the proportion of frivolous cases than reported a decline in the burden lawsuits posed.

Table 12. Termination status of current court orders

	Termination sought, case is pending	Termination sought, rejected by court	Termination not sought
Large jails (n = 17)	18%	12%	71%
Prisons (n = 17)	59%	0%	41%

Court orders. It's clear that the PLRA has opened up opportunities for agencies to end the operation of court orders. Of the 18 prison surveys that reported the legal process by which court orders had been lifted since 1996, two-thirds reported that "termination [was] sought and granted under the PLRA." The

remaining third reported that the orders had expired on their own terms or were terminated because their agencies had been in substantial compliance. Only six jail surveys answered this question, but their answers were similar: five of the six reported that termination was under the PLRA; the remaining one reported termination due to compliance.

Nonetheless, as Table 7 demonstrates, a good many orders remain in operation. The survey results provide some insight into why. The survey asked of each respondent who had reported one or more current order, "Has your facility/jurisdiction recently sought termination of the [current] orders, under the Prison Litigation Reform Act?" As one might predict from Table 7, substantially more of the jail respondents reported that their agencies had decided to forego opportunities to get court orders lifted.

Table 12, page 10, presents fuller data. The survey asked respondents whose jurisdictions had decided not to seek termination to explain why. The answers sort into three types: (1) the orders are useful to the agency, because they help to control population or help prevent individual litigation; (2) the orders are not very onerous to the agency; (3) the PLRA's termination provisions are not applicable, either because the order is new, or (one can infer) because it is a state court, state law order not governed by the PLRA. The third category is applicable to several jail responses, but no prison responses.

Litigation's Importance to Corrections

Since passage of the PLRA, the federal court civil rights inmate docket has shrunk by 40%. But the results of this survey establish that litigation remains extremely important to correctional administrators. It is clear that agencies continue to respond to the fact and prospect of damage and injunctive actions by seeking to avoid lawsuits, by hiring various kinds of staff to respond to litigation, and by reforming policy and supervision in areas that turn out to pose litigation risks.

On the details about how inmate litigation works—its prevalence, topics, outcomes, and impact—different observers will be struck by different aspects of the findings. For me, the most interesting results are:

- Problems in medical care are the preeminent topic of litigation and court orders, for both jails and prisons.
- Jails and prisons report quite different trial experiences: only 14% of large jails reported trial losses, compared to 58% of prisons.
- Both jails and prison respondents report a fairly low amount of damages paid annually, but jails report damage levels notably higher than those in the prison sample.
- Court orders continue to be very prevalent, and prisons are far more likely than jails to seek termination of the orders.

- Both jail and prison respondents rated both individual and class action litigation high in importance to their agencies.

- Jail respondents were more likely to consider individual litigation burdensome, but less likely to consider class action litigation burdensome.

- Both jail and prison respondents reported that court orders were largely beneficial to their agencies' mission.

- Nearly half of the jail respondents, but hardly any of the prison respondents, reported no impact of the PLRA on the number, frivolous proportion, and burden posed by individual and class action lawsuits. ■

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Responding to Inmates with Mental Illness:

Resources for Jail Administrators

by
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The following scenario is common in many jurisdictions: As the inmate population in crowded jail systems continues to rise, the same individuals—who are exhibiting strange or deviant behavior—are booked repeatedly for low-level offenses, and more inmates are placed on costly 24-hour suicide watches. At the same time, county officials press jail administrators for budget cuts.

This scenario—a symptom of the over-representation of people with mental illness throughout the criminal justice system—is disturbingly familiar to large jail administrators across the country. In many communities, jails have become the largest mental health institutions. Rikers Island in New York City and Los Angeles County's Twin Towers Jail house more people with mental illness on any given day than any state hospital or mental health facility in the country.

Although jail administrators do their best to provide services to these individuals, they recognize that the growing numbers of inmates with mental illness —many of them with schizophrenia, bipolar disorder, and/or severe depression— complicate the jail's core mission. Because 75% of the people with mental illness in jails also have a co-occurring substance abuse disorder, the situation becomes even more vexing. As Captain John Caceci of the Monroe County (New York) Jail told the U.S. Senate Judiciary Committee, "We work in a jail, and our job is to incarcerate offenders, not hospitalize sick people."

Fortunately, a number of resources have recently become available to help jail administrators respond to the influx of inmates with mental illness. The Criminal Justice/Mental Health Consensus Project report, the project's interactive Web site, technical assistance from multiple sources, and current and proposed federal grant programs can all offer valuable support to jail administrators struggling with mental health issues as they relate to jails.

Conveying Consensus

The Criminal Justice/Mental Health Consensus Project report, released in the summer of 2002, is a comprehensive guide for criminal justice and mental health

professionals on how to improve the response to people with mental illness who come in contact with the criminal justice system. Recognizing that this issue presents different challenges to various parts of the justice and health systems, the report contains two sections.

- The first half identifies strategies that can be applied throughout the criminal justice process—from before arrest, through incarceration, and after re-entry.

- The second section addresses the overarching themes of collaboration, training, building an effective mental health system, and measuring outcomes—crucial issues for any agency or agent of change.

Along with policy statements and hundreds of recommendations for implementation, the report includes over 100 examples of programs or policies designed to respond effectively to individuals with mental illness who become involved in the justice system.

Many large jail administrators have already begun to use the report as a guide for change, both within the jail and in conjunction with criminal justice and mental health partners. Jurisdictions have found the report especially useful as a tool for helping broad-based task forces involving law enforcement, court officials, jail administrators, mental health and substance abuse practitioners, and local government officials to work together to improve coordination. The report can be viewed, downloaded, or purchased online at *www.consensusproject.org*.

A "Web" of Example Programs

For large jails interested in improving their response to people with mental illness, the first question is usually: "What are other jails doing?" To help answer that question, the Consensus Project has also launched the Program Examples Database, accessible at *www.consensusproject.org/programs/*.

The database contains information about all the programs cited in the Consensus Project report, along with many others that have been added since the report's release. Included are jail diversion programs, transition planning initiatives, and strategies for informing public mental health providers when their clients are booked into jail. Visitors can search the database by keyword, state, issue area, and several other criteria.

Each program has a separate page, maintained by program administrators, that includes a description, contact information, and materials on the program. Perhaps most exciting, the database allows visitors to ask questions of program administrators and other officials who have knowledge of these programs, as well as to suggest new examples for inclusion in the database. With these interactive functions, the database should become a locus for information and dialog about innovative programs.

Partnering to Foster Collaboration: The Consensus Project and the National Institute of Corrections

If there is one point of agreement among corrections administrators committed to improving the response to people with mental illness in the justice system, it is that realizing this goal requires collaboration between the mental health and criminal justice systems. Mental health and criminal justice professionals must understand the overlap of their clientele, appreciate each other's roles, and develop ways to sustain joint efforts. Recognizing this, the Consensus Project is partnering with the National Institute of Corrections (NIC) to provide technical assistance to foster such collaboration.

NIC and the Consensus Project are now developing plans for how to best use their limited resources to help the field. A Corrections/Mental Health Technical Assistance Advisory Group met in May 2003, and the Consensus Project will begin making opportunities for technical assistance available to jurisdictions by late summer or early fall. The project hopes to assist jurisdictions in a number of ways—by providing basic information and referrals, training, presentations, and needs assessments, or by offering help in implementing a particular Consensus Project policy statement or program model. Updates on the availability of technical assistance will be posted on the Consensus Project Web site at *www.consensusproject.org*.

Tapping the TAPA Center for Jail Diversion

In many jurisdictions, the growing number of inmates with mental illness has led to the expansion of jail mental health programs. While there is no question that jails must provide adequate mental health services, building a better health care delivery system in jails involves its own complications. As Arthur Wallenstein, Director of the Montgomery County (Maryland) Department of Corrections, points out, "We need to help people with mental illness in their communities, not wait until they arrive in jail to provide adequate treatment."

Jail diversion—diverting appropriate jail detainees from the criminal justice process into community-based mental health services—is an increasingly common strategy. Jail administrators interested in learning more about jail diversion can now turn to the Technical Assistance and Policy Analysis (TAPA) Center for Jail Diversion, funded in October 2002 by the Center for Mental Health Services (CMHS) of the Substance Abuse Mental Health Services Administration (SAMHSA) as a branch of the National GAINS Center for People with Co-occurring Disorders in the Justice System.

The TAPA Center, which can be reached toll-free at (866) 518-8272 or at *tapacenter@prainc.com*, provides reports and research results, information about existing jail diversion programs, and technical assistance by telephone or on-site. The center will also soon launch its own Web site at *www.tapacenter.org*.

Federal Grants for Jail Diversion and Mental Health Courts

In addition to funding the TAPA Center, CMHS has provided grants over the past several years to support jail diversion initiatives in a number of jurisdictions. Since 1998, CMHS has awarded nearly 30 grants totaling more than $8 million in this area and will announce seven new grantees soon. Until Congress solidifies a FY 2004 budget, it remains unclear whether CMHS will continue to be able to fund grants for jail diversion projects, but jail administrators can check *www.consensusproject.org* or *www.samhsa.gov* for updates on this opportunity.

The U.S. Department of Justice's Office of Justice Programs (OJP) is administering, through the Bureau of Justice Assistance (BJA), another grant program that is relevant for jail administrators. Although the soon-to-be announced grantees for the Mental Health Courts Program will be primarily court systems, and some mental health agencies, many of their projects will require close collaboration with jails. In addition, a portion of the technical assistance resources that BJA plans to provide will be made available to recipients of the CMHS jail diversion grants and the field at large. Jail administrators should check *www.ojp.usdoj.gov/BJA/grant/mentalhealth.html* or the Consensus Project Web site to learn more.

Resources to Promote Collaboration: Pending Legislation

As jail administrators and other criminal justice and mental health professionals struggle on a local level with issues at the interface of criminal justice and mental health, members of the U.S. Congress are becoming increasingly aware of this issue and are working to promote innovative solutions. In October 2002, Senator Mike Dewine (R-OH) introduced the Mentally Ill Offender Treatment and Crime Reduction Act of 2002 with broad bipartisan support. The bill would have authorized $100 million each year in 2003 and 2004 (and funds as necessary from 2005 to 2007) for grants to state and local criminal justice, juvenile justice, and mental health agencies to develop collaborative programs. Activities eligible for grant funding could be coordinated by police, courts, local corrections, or community corrections. Rep. Ted Strickland (D-OH) introduced a companion bill in the House.

Congress did not vote on the bill before the close of the 2002 session, and on June 5, 2003, Senator DeWine re-introduced the legislation as S. 1194, along with Senators Leahy (D-VT), Grassley (R-IA), Cantwell (D-WA), and Domenici (R-NM) as co-sponsors. Rep. Strickland also reintroduced the companion House bill. With broad bipartisan support, the legislation's prospects are good, which could mean a substantial influx of resources for communities grappling with this issue.

Getting It Together

Large jails have been strained for years by the growing number of inmates with mental illness in their facilities—but they are not alone. Law enforcement departments, court systems, prisons, and community corrections officials struggle with similar issues.

Concern extends outside the justice agency arena:

- Criminal justice involvement complicates mental health providers' ability to provide services.
- Crime victims are left to sort out the baffling interface between the justice and mental health systems.
- Local, state, and federal appropriators watch as taxpayer dollars are being spent on expensive crisis and public safety resources.

Moreover, these concerns do not speak to the significant toll that criminal justice involvement takes on the lives of both people with mental illness and their families, many of whom fight daily against these debilitating illnesses.

The resources outlined in this article all recognize that, just as the problem is shared among systems, communities, and families, so must the solutions be shared. While cooperation already exists, to some extent, in every jurisdiction, there remain many obstacles to consistent, effective collaboration.

The importance of overcoming these obstacles cannot be underestimated. As the Consensus Project report emphasizes, "The single most significant common denominator shared among communities that have successfully improved the criminal justice and mental health systems' response to people with mental illness is that each started with some degree of cooperation between at least two key stakeholders—one from the criminal justice system and one from the mental health system."

By tapping into available resources and by working in conjunction with partners in criminal justice and mental health, large jail administrators can take the lead in improving the lives of people with mental illness and their loved ones, thereby enhancing the functioning of their jails and guarding the health and safety of their communities. ■

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National Standards Provide Guidance for

Detention of Aliens

by
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The U.S. Department of Homeland Security (DHS), Bureau of Immigration and Customs Enforcement (ICE), formerly the Immigration and Naturalization Service, is responsible for ensuring that detained aliens are provided with safe and humane conditions of confinement while their cases are in immigration proceedings and while they are awaiting repatriation to their home countries. The detention of aliens is not intended to be punitive but to ensure that they appear for their hearings and for their departure from the United States. Within ICE, the Office of Detention and Removal is responsible for the fiscal and physical monitoring of DHS's detention resources and operations.

During the 1990s, the Office of Detention and Removal experienced phenomenal growth in its detention operations; the average daily population has grown from about 5,000 in 1994 to more than 21,000 today. Fifty-five percent (55%) of these detainees are being held in some 320 local and state detention facilities and jails. It quickly became clear that greater oversight was needed to ensure that the rapidly growing detention program was meeting not only the legal obligations of the government but also the needs of the detainees, facility managers, and staff for safe, secure, and humane conditions of confinement. Therefore, in November 2000, 36 National Detention Standards were introduced.

The National Detention Standards are designed to identify a minimum level of custody and conditions of confinement acceptable to the ICE. The primary purpose of these standards is to provide uniform guidance regarding the detention, safety, and well being of detainees in our custody. Only facilities used in excess of 72 hours are required to meet the standards; facilities used to house detainees for fewer than 72 hours are expected to meet the majority of the standards, using modified guidelines.

The Jail Inspections Program

In 2001, the Office of Detention and Removal determined that its existing jail inspections program did not meet the changing needs of the detention program. The Detention Management Control Program (DMCP) was developed to provide a single method of inspecting all types of detention facility operations. The primary purpose of the DMCP is to prescribe policies, standards, and procedures to establish, maintain, evaluate, and improve detention operations and to ensure that they are operated under safe, secure, and humane conditions for both detainees and staff.

The DMCP consists of a series of events designed to assess detention facilities in a uniform manner, on a regular schedule, and with a focus on priority detention standards. Representatives from the Office of Detention and Removal headquarters and regional and district office staff meet annually to set priorities and identify standards to be revised, based on current trends and emerging issues. These priorities are then used to update the Review Guidelines, the documents that provide guidance for individual facility reviews.

A review of each detention facility is required annually. Once the annual assessment is completed, a schedule of facility reviews is published, and review teams are assembled. After a review is conducted at a facility, the review team produces a report whose results are given to the facility's Chief Executive Officer. The CEO is requested to provide a plan of action for addressing any deficiencies noted in the review.

Flexibility for Local Facilities

The Detention Management Control Program has developed two approaches to conducting detention reviews.

- Facilities owned and operated or exclusively contracted for ICE must meet both the policy and individual procedures of the National Detention Standards.

- Local and state Intergovernmental Service Agreement facilities must meet only the intent of the standards.

The National Detention Standards and the DMCP provide a general baseline approach to applying standards to the confinement of a detainee who is in federal custody. Staff reviewers are given a degree of latitude in determining if an individual detention facility has met the intentions of the standards. We recognize that various localities must meet their own state and local regulations and codes related to detention operations. Because the National Detention Standards do not dictate actual procedures for compliance, local facilities can use a variety of procedures to meet the standards' general intent.

A common misconception about the Immigration and Customs Enforcement review program is that any facility that is not fully compliant with the National Detention Standards is precluded from holding ICE detainees. In fact, facilities generally are precluded from housing ICE detainees only when conditions of

confinement are found to severely affect the welfare and well being of detainees and staff. The DMCP is structured to allow ICE field staff to work directly with providers to make any corrections needed to ensure continued partnerships between the Bureau of Immigration and Customs Enforcement and its Intergovernmental Service Agreement partners.

In 2002, more than 70% of ICE detention service providers received a rating of Acceptable or better. A significant number of identified deficiencies were related to a lack of written policy that supported existing practices within a detention facility.

More Partnership Sites Sought

We will continue to support partnerships with a combination of local and state detention programs to support the safe and secure detention of ICE detainees who are facing removal from the United States. We are always looking for additional locations and facilities that are able to meet our mission requirements.

Additional information related to the ICE National Detention Standards and the Detention Management Control Program is available online:

- Visit the ICE site at *http://www.bice.immigration.gov/graphics/immig.htm.*
- For information on the Office of Detention and Removals, see *http://www.immigration.gov/graphics/shared/lawenfor/interiorenf/custody.htm.*
- Or, refer directly to the Detention Operations Manual on our Web site at *http://www.immigration.gov/graphics/lawsregs/guidance.htm*. ■

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Putting Public Health Services into Practice in the Jail

by
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With the marked growth in prison and jail populations over the past two decades, corrections and health care professionals have come to realize that chronic and infectious diseases and mental illness are concentrated in correctional populations. They are also recognizing the extent to which this circumstance presents a public health opportunity.

The link between correctional health, community health, and public health is particularly important and challenging for jails, where the number of individuals passing through and returning to the community is much higher than in prisons. Because of inmates' limited access to regular health care and their high incidence of risky behaviors, it is important to engage them in ongoing care. Even though the jail population is predominantly young, over 20% of the population have chronic diseases. Developing continuity of care will diminish the spread of disease in the community and will shift some aspects of health care away from from hospitals and emergency rooms.

The Correctional Center and the Community

The Hampden County Correctional Center (HCCC) is a medium security correctional center located in western Massachusetts. HCCC serves Hampden County and metropolitan Springfield-Holyoke, with a population of about 500,000.

The facility houses 1,800 inmates, both detainees awaiting court appearances and sentenced prisoners. Roughly a third of inmates remain 3 days or less, another third for 4 to 90 days, and the final third for 91 days to 2 years. About 75% of the jail population comes from four neighborhoods/catchment areas within the county, each of which has a community health center.

From 2% to 3% of the population from the health centers' primary neighborhoods are in the jail at any given time, and 4% to 5% pass through annually. HIV rates are high in these neighborhoods and even higher within the facility: 5.5%

seropositivity in men and 8.8% in women at entry in 1996. (A more recent report, in 2002, indicated that, of 681 inmates voluntarily tested, only 15 were positive, or 0.89%. This finding is felt to be due to effective programs for prisoners in education and prevention.) On any given day at HCCC, there are between 60 and 80 cases of HIV and approximately 20 persons being treated for latent TB; annually, more than 1,400 cases of sexually transmitted diseases are treated.

The Public Health Model

To address the needs of this seriously at-risk population, the Hampden County Correctional Center, four community health centers, and the Massachusetts Department of Public Health developed a cooperative public health model for corrections. The public health model arose out of a philosophy that recognizes that the jail is an integral part of the community, that those incarcerated are only temporarily displaced members of the community, and that incarceration presents an opportunity to benefit the health of these individuals, their parents and families, and the communities to which they return.

The public health model features five major elements:

- Early detection and a comprehensive assessment of health problems;
- Prompt and effective treatment at a community standard of care;
- Disease prevention programs;
- Comprehensive health education; and
- Continuity of care in the community via collaboration between the HCCC Health Services Department, community health centers, and other local health care providers.

The model as implemented at HCCC includes five key features:

- **Assignment to health team based on zip code.** At admission, inmates with serious chronic medical conditions are assigned to one of four health care teams based on their residential zip code. The HCCC health care teams include one or two physicians, a primary nurse, a nurse practitioner, and two case managers as well as an RN case manager for complicated medical cases and a mental health discharge counselor available for consultations. The physicians and case managers are dually based at the community health center and the correctional facility, and the primary nurse and nurse practitioner are based only at the correctional center.
- **Contracts with community providers.** HCCC has entered into contracts with local community health centers, mental health care, dental health care, and optometry non-profit vendors to deliver services on-site and in the community.

- **Daily triage system.** Registered nurses and masters level mental health clinicians go directly to inmates' living quarters to assess their health status, deliver care via protocols, and respond to non-emergency complaints.

- **Health education.** Comprehensive health education is provided to inmates, especially on the prevention of infectious diseases including HIV and hepatitis, substance abuse, and disease management/self care for patients with chronic disease.

- **Extensive discharge planning and follow-up.** Discharge planning and follow-up are promoted, with the dually based health care providers delivering continued care at their health centers after inmates are released from jail.

It is important to note that the full model (dually based provider teams, case management, discharge planning, and arrangement of post-release appointments) is generally available only to inmates with serious chronic medical conditions, although other inmates in need of short-term attention to medical issues may be eligible on a case-by-case basis. In general, inmates with mental health problems do not receive services from the dually based provider teams. Rather, their HCCC-based discharge planner refers them to appropriate community-based mental health services.

Many elements of this public health model of correctional care are beginning to be implemented in other jail and prison facilities around the nation.

Benefits of the Public Health Model

A comprehensive public health program consisting of early detection and assessment, health education, prevention, treatment, and continuity of care can reduce the incidence and prevalence of disease in correctional facilities and communities. The public health model values wellness, treatment of disease, prevention of illness, and access to care during and after incarceration.

This model delivers high-quality health care based on community standards and establishes close links with providers in the communities to which inmates return. These links ensure continuity of care and the ongoing management of medical and mental health problems. The dual basing of providers at the correctional facility and in the community allows for substantial collaboration between corrections and health care professionals.

HCCC admits and releases more than 5,000 inmates every year. Although inmates are generally in jail for only a few months, the time of incarceration has often been beneficial for them medically. While incarcerated, they receive comprehensive health care treatment and learn to appreciate the value and results of ongoing medical care. Gradually, inmates value health care delivered by providers who are interested in their welfare, and they become more active partners in their own care and treatment. Medical empowerment is a major goal of the program.

Evaluation Findings

HCCC has seen many specific benefits of its public health model of correctional health care, as identified through studies conducted at HCCC.

Improved Inmate Health

- The individual inmate's serious and often unmet health care needs are addressed and ongoing treatment is maintained via discharge planning and continuity of care in the community.

- Providers working at community health centers are often from the local community served and represent the culture of the neighborhood. When staff demonstrate cultural and linguistic competence, communication, and trust, the relationship between inmates and their caregivers is enhanced.

- More than 88% of HIV-positive inmates referred for ongoing care after release from HCCC keep their initial medical appointments at a designated community health center.

- The educational components of the model raise inmates' awareness of their risks for communicable disease and teach them ways to reduce that risk to improve overall health. Inmates learn to manage their own chronic diseases, such as diabetes, to prevent complications.

Improved Public Health

- Each year, the HCCC program introduces comprehensive health care to thousands of high-risk persons who previously went untreated. Most inmates are uninsured, poor, and under-educated about health issues.

- Public health improvement results from immediate care after release. For infectious diseases, adequate treatment and education to prevent future transmission provide tangible public health benefits to the inmates' families, sexual partners, and communities. Early detection and treatment of infectious diseases prevent costly complications.

- The community benefits from the provision of curative treatment for communicable disease, the prevention of secondary infections, and surveillance of reportable medical conditions. Given the number of infectious diseases detected in jails, these facilities may be the first to identify emerging trends in communicable disease patterns, such as the surge in TB in the late 1980s and early 1990s.

- Jails serve a sentinel function for the community. If a jail detects a sudden increase in sexually transmitted diseases, it can warn local public health officials that an outbreak or marked increase may be occurring in the community. Because inmates are admitted to jail directly from the community, the jail becomes a reflection of the community.

- Inmates who have been educated in how to avoid the spread of disease may be less likely to infect others, benefitting overall community health.

- Community health center workers continue linkages via outreach and follow-up once an inmate has returned to the community. They support disease management, recovery from addiction, and the prevention of disease transmission.

- Family and social ties are strengthened as inmates and their families receive care at local clinics. In turn, stronger social ties improve individual and community health.

- Immunizations against hepatitis A and B provided to at-risk inmates improve community immunity and interrupt disease transmission.

- Prenatal care provided to women while in jail improves birth outcomes, prevents vertical transmission of diseases such as HIV, and educates women about well baby care, childhood immunizations, and nutrition.

- Mental health care and substance abuse treatment begun in jail and continued in the community improve overall public health, individual employability, and family and social functioning.

- The public health model lends itself to research projects. The scientific literature needs more research and outcome studies on correctional health issues. Grants to support research are becoming more common in corrections, and research funds often allow program enhancements that otherwise would not occur. Employing staff who have an orientation toward research is extremely helpful in obtaining outside funding and conducting research.

Cost Savings

- Significant downstream savings in community health care costs result from the early and effective detection and treatment of disease.

- In fiscal year 1998, the cost of health care at HCCC was $7.23 per day per inmate, less than the average of $7.89 per day per inmate in a 2001 study of the 30 largest U.S. jails.

- Grants and state contracts have provided substantial funds for HIV/AIDS education, STD and TB screening and treatment, a pilot study of urine chlamydia screening, and reimbursement for HIV medications.

- Substantial savings are realized by using community-based, non-profit providers for health care, pharmacy, dental care, optometry, health education, and mental health services. These services are provided at lower cost than if HCCC used its own staff under state payroll or negotiated salary requirements.

- Community cost-savings are achieved by enrolling eligible inmates into Medicaid, which helps to ensure that, upon release, patients will use community health care services instead of more costly emergency rooms for primary care treatment.

- An in-depth and ongoing study of the cost-effectiveness of treating inmates with HIV/AIDS concluded that the HIV/AIDS programs likely pay for themselves when all costs to society are considered. Potential indirect savings could be as high as $270,000 per participant, depending on adherence and on assumptions about transmission rates and treatment in the absence of the HCCC program.

- Using an economic analysis model based on costs, demographics at HCCC, and effectiveness data from the scientific literature, our research found that providing HIV counseling and testing was cost-saving to the community.

- The community health centers derive financial benefit from their collaboration with HCCC. Contractual agreements pay the centers an hourly rate for staff based at the jail and at health centers. The annual contracts are evaluated, modified, and renewed to cover expenses and provide a predictable source of income for health centers. After inmates are released, their health care costs are covered under third party reimbursements such as Medicaid.

Improved Public Safety

- Health care enhances public safety. When a person is healthy and receiving proper and adequate care, he/she is more likely to exhibit appropriate behaviors, thereby reducing crime in the community.

- Providing mental health and substance abuse treatment to inmates increases the likelihood of their recovery from drug addiction.

- Continued support for recovery from drug addiction can reduce future criminal activity related to acquiring illegal drugs.

Protection of Correctional Staff Safety and Health

- The facility itself benefits. With good health care, inmates are more content and cooperative. Mental health problems, which can adversely affect inmate behavior and facility operations, are properly diagnosed and treated.

- The treatment of infectious diseases among inmates protects the health of facility staff by reducing communicable disease transmission.

Better Use of the Health Care System

- A major benefit of the public health model is a dramatic decrease in the use of the emergency room as the primary care provider. With almost half of the male inmates and nearly two-thirds of the female inmates at HCCC reporting use of local emergency rooms for their health needs in the previous year, the financial and public health drain on community resources was significant. Inmates also reported frequently waiting for symptoms to become severe before seeking care, leading to the need for more costly treatment. Once inmates are released back to their community, they use the community health center to which they were assigned based on their zip code of residence.

- By establishing a relationship with a primary care provider while incarcerated, the inmate develops a greater understanding of the role of primary care, preventive care measures, and how the health care system functions in the community.

- Inmates who are more involved in their own health care acquire knowledge and skills to avoid health risks, learn about positive health behaviors, and become active partners with their providers.

- It is cost-efficient for released inmates to use community health centers to receive consistent, high-quality, primary care delivered in their neighborhoods. HCCC data show that more than 88% of inmates referred for ongoing care after release keep their initial medical appointment at their designated community health center.

Recidivism

- Researchers at HCCC have documented recidivism rates that are lower than national averages. In a 3-year study of inmates released from HCCC in 1998, 36.5% were reincarcerated in a Massachusetts correctional facility between 1998 and 2001. A national study involving prisons in 15 different states and examining a similar 3-year period showed a reincarceration rate of 51.8%. Although many factors affect recidivism rates, researchers believe the lower rate at HCCC is a result of the intensive model of comprehensive health care, education, pre-release support, and ongoing follow-up after release provided in Hampden County.

More Information Online

The Massachusetts Public Health Association Web site has made materials available online that describe the Hampden County public health model. See the Association's Web site at *http://www.mphaweb.org/hccc.html*. The resource document, *A Public Health Manual for Correctional Health Care*, is available on the web in HTML chapter format, and print copies are available on request at no charge. ■

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Corrections Demonstration Project

Fosters Collaboration on HIV in the Community

by
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By the mid-1990s, public health workers who served communities with high rates of HIV and other sexually transmitted diseases (STDs) had begun to notice the strong relationships among disease, drug use, and stints in jails and prisons among those infected with HIV. These relationships were especially pronounced among injecting drug users. From these observations and earlier cooperative work on STD elimination in jails, those in public health developed the idea to create a corrections-based program to provide disease prevention information, early disease detection, appropriate treatment, discharge planning, and community case management.

The Centers for Disease Control and Prevention (CDC) and the Health Resources Services Administration (HRSA) of the U.S. Department of Health and Human Services developed a partnership in 1999 to provide funding for a demonstration project on corrections and community HIV discharge planning and community case management. Competition for program funds available through the "Corrections Demonstration Project" (CDP) was targeted to "high morbidity areas," where rates of HIV were concentrated. Although applications had to come from health departments, they were required to include evidence of a working relationship with a corrections facility. This evidence was often in the form of memoranda of understanding or letters of intent to participate. Seven demonstration sites were funded, all with a jail-based program.

Interrupting the Cycle

The basic premise of the CDP is that correctional facilities offer a prime location for identifying individuals who engage in high-risk health behaviors but who are otherwise difficult to locate in the community. Examples include injecting drug users, prostitutes/sex traders, and young people engaging in high-risk behaviors. Because people in these groups are unlikely to be exposed to prevention

messages or to seek medical care when they become ill in the community, they often become infected with a variety of transmittable diseases.

Those diseases are, in turn, introduced into the jail setting. If offenders are not treated while incarcerated, they will carry those diseases back into the community when they are released. Given that many in these groups are "frequent flyers," their recidivism creates a cycle of community to jail to community, resulting in broad transmission of disease and the deterioration of individuals' health. The CDP seeks to interrupt this cycle by preventing transmission and providing targeted case management of individuals in the jail as well as continued follow-up once they are released back into the community.

Through partnerships among health departments, jails, and community-based organizations, CDP demonstration sites ensure that these high-risk individuals receive:

- Exposure to prevention messages concerning diseases such as HIV/AIDS, STDs, and hepatitis B and C;
- Screening for sexually transmitted diseases;
- HIV counseling and testing; and
- Information on the prevention and treatment of hepatitis B and C as well as, in some locations, hepatitis B vaccinations.

For detainees found to be HIV-infected or who disclose their status, a case-worker conducts a needs assessment and develops a discharge plan prior to the individual's release from the jail. Jail medical staff can stabilize infected detainees as well as develop an individualized treatment regimen that can be carried back into the community.

Reliance on community-based case managers. Knowledge of existing community resources for HIV-infected persons is a key ingredient of a successful program. In most demonstration sites, the jail-based programs work closely with local Ryan White Care Act community-based organizations to allow case managers access within the jail to inmates to do a needs assessment and develop a discharge plan.

Although the degree to which case managers are integrated into the flow of jail routine varies across demonstration sites, their presence has generally been viewed as a positive addition to the resources of the jail. The discharge planners and case managers provide a link back into the community for the inmate. They also act as a community support for individuals to remain on medicines and to access the services they need to reduce the impact of their illness on the community.

The role of the case manager is critical to the success of the program. When inmates are returned to the community, case managers assure that they keep appointments and assist them with emerging needs. In some programs, a single

case manager may coordinate all services for a client within a "one-stop" agency. In other programs, one case manager may make referrals to other agency case managers and oversee these agencies' delivery of services to the client.

Evaluation. The Corrections Demonstration Project also includes an evaluation component. Among the evaluation questions are: What percentage of the HIV-positive inmates know their status upon entry vs. how many detainees learn of their status as a result of CDP counseling and testing efforts? How many HIV-positive individuals require medication upon release from jail, and how many are not at the point to require prescribed medication?

For the purposes of the evaluation component, clients are followed for 6 months after their return to the community. The types of services accessed, the frequency of access, and the impact of these services on the health status of the individual at the 6-month point are assessed. Social readjustment and recidivism rates among the clients are also examined.

Project goals. The project emphasizes the inter-relatedness of public safety and public health in our communities. Particularly in larger urban areas, the effort to reduce the burden of HIV on communities is much more difficult without the involvement of the local jail. In turn, by focusing on the substantial health and social support needs of HIV-infected individuals who cycle through jails, we may begin to address the behaviors that place them at risk of arrest and detention. Keeping former inmates healthier in the community may also reduce the medical costs for the jail if the individual is arrested again at a later date.

Jails are the largest single provider of HIV, substance abuse, and mental health services in the community. Programs such as the CDP make jails a key to the improvement and maintenance of health in the community. The health of the community, in turn, influences the medical costs of the jail.

Expanding the Model: The LINC Program

One of the most active CDP sites is the LINC ("Linking Inmates Needing Care") program operating in the Jacksonville (Florida) Sheriff's Office (JSO) Department of Corrections. JSO's contracted medical care provider, Correctional Medical Services, Inc., is responsible for the medical management of HIV-positive inmates. The LINC program provides all of the essential health screening, health promotion, discharge planning, and case management services that make up the CDP model approach. A JSO correctional officer is assigned full-time to the project to serve as an interface between custody and program operations.

The program represents a partnership among the JSO, CMS, the regional office of the Florida Department of Health, and a range of community-based organizations, community mental health providers, and state universities. A "continuity of care" philosophy is shared across these organizations, with the jail as the cornerstone. This approach is different from other CDP projects, in which there is sometimes a tendency to focus on the HIV status of an individual and to see other services as supportive.

The Jacksonville LINC program views substance abuse and mental health as core issues for most of its HIV-positive inmate clients (as well as HIV negatives), and it orients services around these problems. From the experience of the jail-based staff, the substance use and mental health conditions must be addressed, or it is unlikely that the incarcerated HIV-positive clients will continue treatment when they are released. There is also a greater likelihood that these individuals will cycle back into the jail in worse health than at the previous arrest.

Enlightened self-interest on the part of the JSO Corrections Department has played a role in the development of LINC. The staff reports that the program has improved inmate behavior in the jail. They note fewer incidents of violence among the inmates and toward staff and less need for involuntary chemical restraints and hospitalization. Once the inmate is back in the community, the case management approach has resulted in substantial reductions (up to 55%) in the re-arrest of participating clients. In short, the jail benefits internally because fewer resources are used, stays are reduced, and fewer individuals return to custody.

Case management aspects. In the Jacksonville LINC model, Lutheran Social Services (LSS) provides case management oversight for the other medical, mental health, and substance abuse services to which inmates/clients may be referred. The case management process begins inside the facility, as case managers meet with inmates to develop individualized discharge plans. Case managers also assist inmates in completing paperwork they will need to access programs and entitlements after they are released from jail, thus avoiding disruptions in medication supplies. On being discharged, clients are escorted directly to services.

One client may have case managers from as many as six agencies, but all are supervised by LSS to ensure that clients are following up and receiving needed services. A weekly staffing is held at the jail, in which all in-jail and community clients are discussed. The staff reports that, to date, no clients have been lost to follow-up in the community.

As expected, there is still recidivism among LINC clients, but it has been greatly reduced. A local evaluation component will provide a complete analysis of the program's impact in the near future, but so far the data are quite encouraging. The early experience has also led to the development of LINC programs at other Florida jails, funded with state general revenue dollars.

The Development of Community-Oriented Corrections?

The Jacksonville LINC program is an example of how a basic program that uses Ryan White funds for HIV-positive individuals can expand to address other issues that affect jails and the communities they serve. Although we often tend to equate "co-occurring disorders" only with substance abuse and mental health, we find, in practice, that there are often multiple co-occurring (or co-morbid) conditions that involve substance abuse, mental health, and infectious and/or chronic disease.

Such conditions are often embedded in the economic and social conditions of our communities. The experience of Jacksonville, where "hot spot" mapping of both disease and crime rates showed that both were highest in concentrated zip code areas, is not substantially different from that of other communities where such mapping exercises have been done. (Unfortunately, we have seen these same relationships since the 1920s and the work of the "Chicago School" in criminology.)

We have had the opportunity to visit a number of jails around the nation that are not part of our CDP demonstration project. It is clear that in jurisdictions where community policing forms the core philosophy of a sheriff's law enforcement approach, the development of CDP-style programs is more likely than in places without such a focus. Perhaps we are witnessing the birth of a "community/problem-oriented corrections" philosophy that views jails as components of community problem-solving, rather than simply as places to warehouse offenders.

Some large jail systems have developed a wide range of post-release medical and social welfare case management programs that address issues related to criminal behaviors and recidivism. Examples include:

- Los Angeles County, California;
- Harris County, Texas;
- East Baton Rouge Parish, Louisiana;
- Rikers Island, New York City, New York;
- Cook County, Illlinois; and
- Hampden County, Massachusetts.

Examples include Los Angeles County; Harris County, Texas; East Baton Rouge Parish, Louisiana; Rikers Island, New York; Cook County, Illlinois; and Hampden County, Massachusetts.

As several of the people whose work and experience we report here have noted, such programs require leadership from sheriffs and chief jail administrators, who can then engage other organizations not generally associated with the work of local corrections agencies. Local corrections and law enforcement leaders are often in a position to see the correlates not only of criminal behavior, but also of substance use (including alcohol), mental illness, and disease. The local jail is sometimes the lowest common denominator around which communities can begin to develop potential solutions to community problems. Such efforts are not easy, and they require new ways of thinking.

Jails Are Key Partners

Large jail management teams can play a key role in the development of continuity of care approaches to medical issues, such as HIV/AIDS, substance abuse and mental health treatment, and, perhaps, economic issues. We at the Centers for Disease Control view jails as key partners in our efforts to reduce health disparities around the country, especially in large urban areas.

This role not only requires jail managers to think of their position differently, it also aims to change a community's view of its jail. Jails are active partners in our communities, not sequestered buildings whose inhabitants are ignored by the community. In effect, we are asking jail management teams to take on one more, perhaps thankless, task.

We believe that jail managers who grasp this problem will make an impact on their communities that cannot be ignored. We look forward to being partners with you in this endeavor. ■

Resources

For more information about the Corrections Demonstration Project, please see the following resources:

Articles:

Laufer, F.N., et al. 2000. “From Jail to Community: Innovative Strategies to Enhance Continuity of HIV/AIDS Care." *The Prison Journal* (82), 1: 84-100.

Rapposelli, K.K., et al. 2002. “HIV/AIDS in Correctional Settings: A Salient Priority for the CDC and HRSA.” *AIDS Education and Prevention* (14), Supplement B: 103-113.

Web site:

The Evaluation and Program Support Center for the Corrections Demonstration Project: *http://www.sph.emory.edu/HIVCDP/index.html*

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Keeping Cops on the Street with Regional Processing

by
Milton M. Crump, Special Assistant to the Director, Prince George's County Department of Corrections

Prince George's County, Maryland, established in 1696, covers almost 500 square miles and has a population of 801,515 in its 38 communities, towns, and cities. Four agencies are responsible for public safety in the county: the Prince George's County Police Department, the Fire Department, the Department of Corrections, and the Office of the Sheriff. There are also 24 individual municipal police agencies and state and federal law enforcement agencies in these communities. In the past, these agencies worked primarily independently of each other, making approximately 40,000 arrests annually.

Problems with Processing of Arrestees

As the county grew in terms of both population and criminal activity, county administrators began to reevaluate the county's use of resources and its way of handling arrested persons. For many decades, the task of processing arrested persons had been a public safety concern. As early as 1979, public safety agencies in Prince George's County attempted to address the problems and inefficiencies of a decentralized arrest processing system. At that time, public safety officials noted that arrest processing procedures were time-consuming, inefficient, hazardous to officers, and fragmented across individual agencies.

Major concerns centered on a variety of procedures. Arresting officers were responsible for completing all documents related to arrest and booking. The result was a very high level of errors and omissions on both arrest reports and fingerprint cards. Problems included the following:

- **Fingerprinting.** Arresting officers used ink to fingerprint each offender three times, once each on federal, state, and local fingerprint cards. A high proportion of these prints were difficult to classify or could not be classified at all because of inconsistencies resulting from rolling the same finger repeatedly in ink.

- **Photographing.** Photographs of arrestees were captured using expensive 35mm or 70mm still photography, which then had to be processed, resulting in the temporary inaccessibility of photos to other agencies that might otherwise use them for photo spreads or line-ups.

- **Hand-writing arrest reports.** All arrest reports documenting details such as the arrestee/suspect's name, vital information, statement of charges, and incident information were handwritten repeatedly three or four times for each arrest and for each individual arrested. An officer with multiple arrests on one case could end up completing 15 separate handwritten documents that contained repetitive text and information.

- **Waiting for a District Court Commissioner.** In the next step, the arresting officer had to wait for an available District Court Commissioner for an initial appearance hearing, which is required by Maryland State Law. At times, depending on Commissioner availability, the officer would have to take the offender to another location, which extended the amount of time the officer was off patrol.

- **Transporting inmates.** After the hearing, arrestees who were not released on personal recognizance or bond were committed to the custody of the Department of Corrections. In such cases, the arresting officer would have to transport the committed arrestee to the correctional facility in Upper Marlboro or keep him in custody at the police facility and wait for transportation assistance from the sheriff or the Department of Corrections. Because of the number of law enforcement agencies operating in the county, it was difficult to arrange for timely pick-ups to a correctional facility. A committed arrestee often had to wait for several more hours at the police facility, requiring an arresting officer to maintain custody even after the processing was complete.

- **Injuries to officers and arrestees.** With arresting officers handling and processing their own prisoners, law enforcement agencies in the county dealt constantly with incidents that resulted in injury. The most serious occurred in 1978, when two police officers were killed by gunfire in a police processing area. The officers were shot and killed by an arrestee who obtained and used one of the officer's service revolvers while being processed. This was one of the many incidents in which there were allegations of excessive force being used against prisoners being processed.

In addition, arrestees were processed at multiple police facilities, which used different report formats, a variety of arrest photographs, and inconsistent fingerprinting methods. The time from arrest to release or commitment to the custody of the Department of Corrections ranged from 3 to 6 hours on average. The arresting officer was kept of patrol the entire time, often for the remainder of the shift, or even beyond it, thus requiring overtime pay.

The Solution: County-Wide Processing

Our Regional Processing Initiative was developed as an innovative approach to prisoner processing in response to these problems. In July 1996, a committee was formed to evaluate prisoner processing in the county and to develop a comprehensive approach to addressing the many public safety issues.

The committee was formed with representatives from all of the Prince George's County public safety agencies, the county's Office of Management and Budget and Office of Central Services, Maryland state law enforcement agencies, the Fifth District Court for Maryland, various municipal law enforcement agencies, and other state agencies. After a 4-month planning phase, the committee announced an initiative that allowed any law enforcement agency (federal, state, or local) placing a person under arrest in Prince George's County to process the arrestee at any one of three regional processing locations. The processing sites were strategically located, one each in the northern, central and southern areas of the county. The three sites provided easy access for any law enforcement agency operating in the county to deliver prisoners for processing.

Based on the concerns identified with the previous system, the goals for the Regional Processing Initiative were as follows:

- To reduce the time it takes police officers to process a prisoner and return to their street duties. By returning police officers to street patrol, planners expected a reduction in crime and an increase in arrests. Jurisdictions around the country that used a central prisoner processing concept had experienced as much as a 25% increase in arrests.

- To limit the probability of confrontation during processing, thus reducing potential conflicts and the injury of either suspects and police. A neutral Department of Corrections processing officer was expected to reduce confrontations between police and arrestees in custody. Excessive force complaints and resulting civil litigation were expected to decrease as there would be less contact between the arrestee and the arresting officer during processing.

- To automate prisoner processing and eliminate the duplication that had occurred in data collection, thus improving the entire process for law enforcement officers, commissioners/courts, and corrections. Creating an automated process and communicating with a central database was expected to ensure the positive identification of offenders. Identification would occur through the use of digitally captured fingerprints linked to a state database. Automation would eliminate the redundancy involved in collecting multiple data for arrest booking and reduce the inaccuracies.

Data systems interface. The new, totally automated booking system created an interface with all police agencies, District Court Commissioners, state records, and corrections. The system was integrated with Maryland's Automated Arrest Booking system. It included inkless fingerprint scanning with simultaneous transmission to the state fingerprint repository, the county's Regional Area Fingerprint Identification Scanning system, and the Federal Bureau of Investigation. Mug

shots were replaced by video imaging that is electronically transmitted to the state as well as stored locally. Video images and arrest information are accessible by any police facility, regardless of where an arrestee was processed.

The automated booking system allows officers to enter data on arrestees and offenses one time at the booking center. Data screens for all other agencies, including Corrections and Court Commissioners, are automatically populated as a result of this initial data entry.

The automated data collection program is generic in its design to allow any law enforcement agency operating within the county to generate necessary reports containing its own letterhead and agency identification numbers. The program is also designed to interface with the courts and state records systems to create a network of communication and allow all agencies to share vital prisoner information.

Streamlined procedures. After an arrest, the arresting law enforcement agency officer arrives with the arrestee at a Regional Booking Center. Correctional staff initiate the Automated Booking System by collecting property, taking fingerprints and photos, and recording initial information in an automated format. The law enforcement officer can then leave the intake area and go to a booking room to begin writing reports such as the Statement of Charges, Statement of Probable Cause, and Arrest Report. All information initially collected in the automated format is used in all of the officers' reports, reducing duplication.

As soon as the reports are completed, the law enforcement officer can return to street patrol. The correctional officer checks the criminal history and completes the process by taking the arrest documents and the prisoner to district court for an Initial Appearance Hearing. If the arrestee is committed to custody, the Department of Corrections arranges transportation to the detention center. If the arrestee is not committed to custody, the correctional officer checks the criminal history again to ensure there are no other pending charges, returns all property, and releases the person.

Costs and Benefits

The law enforcement agencies that use the regional processing sites benefit significantly from the program—and so does the community. The efficient handling of each arrestee allows the patrol officer to return to the community in a little over an hour.

The new processing method has also virtually eliminated the confrontations that resulted in conflict and injury. At the regional processing locations, the arresting officer is separated from the arrestee on entering the processing area. There have been no injuries to any police officer nor any use of force complaints related to processing since the program began. More than 72,000 prisoners have been processed at regional processing locations since the first site opened in October 1996.

The process of conducting criminal history checks on-site before the Initial Appearance Hearing has allowed correctional officers to identify arrestees with open warrant charges. While the arrestee is still in custody, these charges can be satisfied and the warrant closed. Since initiating this phase of the program in October 1998, more than 19,700 arrestees with open warrants have been identified and processed.

The most significant achievement has been the development of the Automated Booking System. Online data entry and communication have created an efficient, user-friendly system that handles arrestees more efficiently and meets the data needs of all the organizations involved. The accurate and ample information provided during the Initial Appearance Hearing also gives the District Court Commissioner more options for releasing individuals on their own recognizance and reduce intake at the Department of Corrections.

The municipal police agencies, which account for approximately 23% of the arrests in the county, were approached after a year of using the automated system at one regional processing site and agreed to assist with staffing support. This "shared staffing" began in January 1998 and is based on the percentage of use by each municipal agency. The concept has been implemented at each regional site and has also been enhanced with support from state law enforcement agencies.

The reduction in processing time created by the Regional Processing Initiative equals an estimated 195,000 to 340,000 in staffing hours that have potentially been saved. Estimated cost savings use the top pay of a Prince George's County Police Department Corporal (straight time; no overtime = $26.67 per hour) to show potential police staff savings based on the 70,000 arrests processed at regional processing sites. If overtime rates were applied, since many of the previous arrests involved overtime, the potential cost savings would be about 50% percent greater.

A comparison of previous arrest processing time involving police officers (estimated using an average of 5 hours; actual times ranged from 3 to 6 hours) and the current processing time for officers (1.2 hours) demonstrates our success in returning officers to patrol. (See Table 1.) We anticipate that processing time will continue to decrease.

Table 1. Officer downtime savings with regional processing

Previous processing time (70,000 arrests x 5 hrs./officer)	Current processing time (70,000 arrests x 1.2 hrs./officer)
350,000 police officer hours	84,000 police officer hours
266,000 downtime hours saved	

Uniform Crime Report data for Prince George's County from 1996 through 2000 show a continuous reduction in crime since the first regional processing site was opened in October 1996. (See Tables 2 and 3.)

Table 2. Prince George's County Police UCR Crime Index Report, Category 1 Offenses

	2000	1999	1998	1997	1996
Homicide	67	88	104	77	132
Forcible rape	198	236	262	279	296
Robbery	2,540	2,135	2,722	2,813	3,466
Aggravated Assault	3,698	3,478	3,878	3,142	3,413
Total Violent Crime	6,503	5,937	6,966	6,311	7,307

Table 3. Crime Rate Index (crimes per 1,000 residents)

	2000	1999	1998	1997	1996	1995
Prince George's County	53.6	53.0	58.6	57.1	64.3	67.0

Obstacles to Replicating the System

Agencies interested in replicating the Prince George's County program would need to consider the following issues:

- The Automated Booking System, with its unique format for incident-based report writing, is a Windows-based computer program that can be installed on any compatible system. A potential obstacle is an agency's ability to develop generic forms and reports. This is necessary to eliminate redundancy among law enforcement agencies' needs within a specific geographical area.

- The booking facility must be designed to separate arresting officers from arrestees, thus reducing potential conflict. This requires a report/booking room and a separate processing area operated by staff other than arresting officers.

- Development and implementation time are possible obstacles. This program was developed with the support of multiple agencies. The routine processing of prisoners within the county was reshaped, which required policy and procedure changes.

- Training requirements are substantial. The Maryland Police and Correctional Training Commission approved all training developed for the booking system. Currently, 39 law enforcement agencies use the regional processing sites. Approximately 1,400 Prince George's County Police Officers received training in the Automated Booking System, and approximately 350 officers from the municipal, state, and federal law enforcement agencies that operate in the county have been trained. A total of 6,800 training hours were conducted to implement the Automated Booking System.

Net Results: Savings and Safety

The Regional Processing Initiative has been a successful approach to creating a more efficient and effective prisoner processing system in Prince George's County. Several key factors were considered during its development and have contributed to its success. The complexity of operations required a well-defined plan. Coordinating the effort took time, cooperation from multiple agencies at all levels, and funding from the county government to build and design the planned processing locations.

Increased police presence in the community helps stop criminal activity. The direct result is a reduction in crime and safer communities. Because of this, there is a nationwide effort to put additional police officers on the street faster and decrease the overtime costs associated with processing arrestees.

The citizens of Prince George's County have benefitted from a reduction in criminal activity as a result of this initiative. Safe communities open the door for business opportunities, encourage population growth, and improve the overall economy. Our Regional Processing Initiative is cutting costs and Keeping Cops on the Street. ■

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